PRINTED: 01/19/2023 FORM APPROVED OMB NO. 0938-0391

	C 1 2/29/202	C 2/29/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET		
SIGOURNEY, IA 52591		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPL	(X5) COMPLETION DATE
F 000 INITIAL COMMENTS F 000		
Correction date: The following deficiencies resulted from investigation of complaints #105144-C, #105319-C, #105324-C, #106838-C, #107305-C, 109293-A and #109300-A conducted December 5, 2022 to December 29, 2022. Complaints #106838-C, #109293-C and #109300-C were substantiated. The findings of #109293-A and #109300-A will be sent at a later date under a different cover. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C. F 550 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) \$483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. \$483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. \$483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IA0662

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED	
		165381	B. WING		1	C 2/29/2022
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591	<u> </u>	2/29/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	practices regarding to provision of services residents regardless. §483.10(b) Exercises. The resident has the rights as a resident or resident of the Universident can exercise interference, coercion from the facility. §483.10(b)(2) The resident can exercise interference, coercion from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility and to be suppexercise of his or he subpart. This REQUIREMEN by: Based on clinical regresident interviews, resident interviews, resident when he atternation for one of four resident when he atternation for the facility reported. Findings include: According to the Minassessment tool with Date of 10/26/22, Residenting moderated indicating moderated.	naintain identical policies and transfer, discharge, and the aunder the State plan for all of payment source. of Rights. right to exercise his or her of the facility and as a citizen ited States. acility must ensure that the e his or her rights without an, discrimination, or reprisal esident has the right to be coercion, discrimination, and lity in exercising his or her ported by the facility in the rights as required under this T is not met as evidenced cord reviews, staff, and the facility failed to ensure a dignified existence, as the retaliated against that empted to exercise his rights ents reviewed. (Resident #4)	F 55	50		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		OMPLETED	
		165381	B. WING _			C 12/29/2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVIN	G CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591	•	TEIESIEGEE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	Continued From page transfers, mobility, depersonal hygiene ne included renal insuff. In an interview on 12 #4 stated that when facility, he was told to Resident #4 stated the Later, when he was wanted him to move Resident #4 stated the empty rooms in the with the ex-Administ XAdmin was fired a place and insisted him stated they wanted thallways. Resident #4 stated the incommate and then Resident #4 stated then Resident #4 stated then in out the front do not have a place to get a sould be read to the stated to the stated to the stated then the stated the stated then the stated then the stated then the stated then the stated the stated then the stated the stated then the stated the	ressing, toilet use, and eds. Resident #4's diagnoses iciency and diabetes mellitus. 2/14/22 at 2:25 p.m. Resident he initially admitted to the ne could have his own room. ne was skilled at that time. no longer skilled, the facility				
	#4 stated he called I his ex-wife's home. steps and was taker hospital. When he to stated they can't jus kept him for two day arrangements for hir Resident #4 stated I small room that was to get to his bathroot to go to an empty robathroom. Resident	nis nephew and got a ride to I hat evening he fell down her I by ambulance to the I bld his story, the hospital I kick you out. The hospital				

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F 550	Continued From pag stated they had just weeks ago. In an interview on 12 Ex-Director of Nursir the DON from April the 2022. The XDON state the new Administrate moving residents in room for private pay there was no waiting and no immediate new XDON stated Reside roommate and argue mentioned. On 8/3/2 with Resident #4 refused informed. According Administrator went to escalated. The Adminurse's station area leaving against medithe paperwork. The XDON upset. The XDON stated she was Resident #4 left and corporate office. A zero.	brought in a roommate two 2/20/22 at 3:20 p.m. the ag (XDON) stated she was brough November 14th, ated shortly after the arrival of or, they were directed to start with roommates to make residents. The XDON stated list for private pay residents eed for vacant rooms. The ent #4 did not want a ed whenever it was 2 the XDON again discussed out getting a roommate. and the Administrator was	F 5	DEFICIENCY		
	In an interview on 12 Ex-Social Worker (X several changes in n When the current Adalmost immediately by	the XDON. 2/20/22 at 4:19 p.m. the SW) stated the facility had nanagement in the past year. ministrator started, she				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
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		165381	B. WING			12/	29/2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	CAMPUS		90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH STONE STREET IGOURNEY, IA 52591		
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F 550	for roommates since is been in rooms for a loseveral vacant rooms instructed the XSW to notices, which include stated she was able to alternative placement placement for Reside roommate issue came not understand why how Administrator and the room. Resident #4 was have a roommate and yelling at him, stating or leaving AMA, what Administrator would respeak and keep saying roommate or AMA. Refinally said I'm leaving fine, have him sign the the maintenance guy them outside the front escorted out. The XS was present and escorted front door. According to a Social and written by the XS let Resident #4 know his items to his side of the closest and Resid got loud in the lobby at then said by law it is to live that he likes. T	V stated she did not administrator was pushing several of the residents had ong time and they had at the Administrator of start giving 30 day eviction at Resident #4. The XSW of assist some residents with at the the could not find ant #4. On 8/3/22 the at the eup again. Resident #4 did the needed a roommate. The at XSW went to Resident #4's as asking why he had to did the Administrator began you are getting a roommate.	F	550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	S CAMPUS		STREET ADDRESS, CITY, STATE, 900 SOUTH STONE STREET SIGOURNEY, IA 52591	ZIP CODE	.2.20/2022
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F 550	Local Deputy Sheriff was called to the faci peace regarding a te Two residents, Resid being asked to share pending admission fr was very upset and g share a room or leav obvious Resident #4 felt he had no choice entered his room, plabags and escorted R with his belongings to left him. The LDS statifiend and went to his wife lives, who is in the LDS stated he did not facility could force a mo place to go. In an interview on 12 Administrator was as conversation with Re Administrator asked #4 left AMA? The Administrator stated conversation she had Administrator was as it was necessary for The Administrator stated to the Administrator stated conversation she had Administrator was as it was necessary for The Administrator stated to the Administrator stated to the Administrator stated conversation she had Administrator was as it was necessary for The Administrator stated to the Administrato	/21/22 at 10:53 a.m. the (LDS) stated on 8/3/22 he lity to intervene and keep the nant dispute with the facility. ent #4 and Resident #5 were a room to allow room for a om the hospital. Resident #4 given the choice to either e AMA. LDS stated it was did not want to leave, but he . The LDS stated the staff need his belongings into trash esident #4 in his wheelchair, to the front of the building and sted Resident #4 called a shome in Arson where his ne process of divorcing. The off feel it was right that a resident onto the streets with resident #4 on 8/3/22. The if that was the day Resident ministrator then stated she ecce by marriage, so she omeone else talk to him. The she did not recall the did with him that day. The ked if she remembered why Resident #4 to share a room. atted she did not recall, noting	F	550		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			NSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		165381	B. WING				29/ 2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	CAMPUS		900 S	ET ADDRESS, CITY, STATE, ZIP CODE OUTH STONE STREET URNEY, IA 52591	1 121	20,2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	e 6	F	550			
	12:00 p.m. and writte	ess note dated 8/3/22 at n by the XDON, Resident #4 ere discharged AMA and he him up.					
F 580 SS=D	Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.))(i)-(iv)(15)	F	580			
	consult with the resid consistent with his or representative(s) where (A) An accident involves results in injury and his physician intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-the clinical complications (C) A need to alter the a need to discontinue treatment due to advect commence a new form (D) A decision to transesident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and proviphysician. (iii) The facility must a resident and the resident there is-	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or an existing form of erse consequences, or to an of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment					

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F 580	State law or regulati (e)(10) of this sectio (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a come that is a composite of §483.5) must disclosite physical configur locations that compart, and must spectrom changes betword under §483.15(c)(9) This REQUIREMENT by: Based on clinical resinterviews, the facility physician or notify the persistent and excredecline, and mental manner. (Resident facensus of 24. Findings include: According to the Minassessment tool with Date of 10/20/22, Resident #1 require transfers, mobility, of personal hygiene neincluded coronary and included coronary and incl	dent rights under Federal or ions as specified in paragraph in. t record and periodically (mailing and email) and e resident posite distinct part. A facility distinct part (as defined in see in its admission agreement ation, including the various rise the composite distinct ify the policies that apply to een its different locations	F 5	80		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		165381	B. WING				29/2022
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F 580	Continued From pag	e 8	F	580			
	Certified Nurse Aide Tuesday, 11/29/22 st 2:00 p.m. shift. That already up in her reconstruction Resident #1 usually st 10:00 a.m. Resident headache and construction At 6:15 a.m. Staff A romplaints of a sevenurse who happened The Administrator if the fatold no, so Staff A go placed them on Resident #1 was been given pain med Administrator if the fatold no, so Staff A go placed them on Resident #1 was been given pain med Administrator if the fatold no, so Staff A go placed them on Resident #1 was been given pain med Administrator if the golden was usually cognitive conversation, but Resident #1 was also continued to complai Staff A stated she con Administrator that Resident #1 was also continued to complai Staff A stated she con Administrator that Resident was usually staff a stated she con Administrator that Resident was usually cognitive conversation, was in and could walk indep Resident #1 was also continued to complai Staff A stated she con Administrator that Resident was usually staff a stated she con Administrator that Resident was usually cognitive conversation, was in and could walk indep Resident #1 was also continued to complai Staff A stated she con Administrator that Resident was usually cognitive conversation, was in and could walk indep Resident #1 was also continued to complai Staff A stated she con Administrator that Resident was usually cognitive conversation, was incompleted to complain the province of the provinc	ation room than attending to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
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NAME OF PROVIDER OR SUPPLIER		•	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
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including Resident #2 commenting to the Adwas crying and wanting A stated Resident #1 stated I was a nurse A stated Staff B and Staff A stated Staff B and Staff A stated and staff A to get a stated once she begand she knew immediated Resident #1 was unated Staff A to get a stated once she begand she knew immediated Resident #1 was unated Staff A commendated Staff A stated she changed times that day and Rany signs of improve Monday, 11/28/22, Randependent and in the normal and by Wednivegetable. On 12/7/22 at 8:45 a. clarification. Staff A s	sruptive that residents 2 and Resident #3, were also dministrator that Resident #1 ing to go to the hospital. Staff was crying in pain and and this is not normal. Staff Staff C also witnessed or help that day, but nothing ated she returned to work at ing day (11/30/22). In report, ed Resident #1 continued to rolled out of bed. Resident once she seemed to calm 0 a.m. Staff A checked on int #1 was soaked in urine of her knees. The nurse, Staff dents lack of care and give her a bed bath. Staff A an attending to Resident #1 by that she had had a stroke. The ing in her eyes, she was like ing in her eyes, she was like ing in her eyes, she was like ing in her eyes, she has iff E responded maybe. Staff d Resident #1's bed three esident #1 never showed ment. Staff A stated on	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED	
		165381	B. WING		ı	C 29/2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591		23/2022
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F 580	day. Staff A stated Rego to the hospital. Sta Administrator knew of #1's request to go to #1'z remembered Resider with staff, independer and being her normal needed assistance w Tuesday, 11/29/22, Suntil 2:00 p.m. That m Resident #1 was comthe morning progress worsened into a migrarequesting to be sent Administrator stated to something and stated complains, but she is never saw the Admini #1. Resident #1 contine excruciating headach her call light throughowould say I was a nume, but no one did. On 12/7/22 at 11:50 a for clarification. Staff with the Administrator informed her that Resigo to the hospital. At said she already gave The Administrator add she is fine.	re headache throughout the esident #1 was requesting to aff A explained that the f her condition and Resident the hospital. 5/22 at 4:55 p.m. Staff B, worked 6:00 a.m. to 2:00 e8/22. Staff B stated she at #1 being alert, conversing only mobile using her walker, self. Resident #1 only ith incontinence cares. On taff B worked from 6:00 a.m. norning when she arrived, aplaining of a headache. As ed, Resident #1's headache aine. Resident #1 began	F 58	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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		165381	B. WING			12/	29/2022
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F 580	a.m. on 11/29/22. Sapproached her with #1. The aides stated complaining of an erequesting to go to indicated they had is several times, but stated she went to the expressed her concident she had given Resispain medication) and for a urinalysis. State Administrator never that day. Staff C state #1 was grabbing at Resident #1 wanted stated Resident #1 most of the day comby late that afternoof garbled. She was no right side vision. knowledge no one of Resident #1 or sought attention. On 12/7/22 at 8:08 clarification. Staff C #1's requesting to ginforming the Admin condition that day a afternoon when Resigarbled and she be In an interview on 1	everal of the aides ch concerns related to Resident d Resident #1 was excruciating headache and the hospital. The aides informed the Administrator he was doing nothing. Staff C che Administrator and the homistrator and the remarkable of the administrator stated dent #1 a Tramadol (controlled dent #1 a Tramadol (controlled dent #1 a Tramadol (controlled dent #1 a Tramadol (staff C che administrator stated dent #1 a Tramadol (controlled dent #1 a Tramadol (contro	F	580			
		11/29/22 and was assigned					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 580	Continued From page	e 12	F	580			
		The scheduled nurse called					
		or covered for the absent					
		the Administrator remained					
		m cleaning and organizing					
		D stated she started setting					
	up medications when	Resident #1's call light					
	came on, so she resp	oonded. Resident #1 was					
	complaining of a hea	dache. Staff D assisted					
	Resident #1 to the to	ilet. Resident #1 was having					
	_	nich was unusual for her.					
		#1 to the toilet and returned					
	to her medication car						
		urned and helped Resident					
		ave her a blanket. Moments					
		s hollering for help. Staff D					
	,	:14 a.m. and then again s Resident #1 continued to					
		help. Other aides voiced					
	-	9:00 a.m. Staff D asked the					
		k on Resident #1. Staff D					
	stated the Administra						
	Resident #1 during h						
	_	multiple times. Staff D					
		ss because the Administrator					
		g. Staff D stated she was on					
	l	it setting up medications					
		n. until 12:00 p.m. Upon					
	returning, Resident #	1 was continuing to cry out					
	in pain. Staff D said s	something to the					
	Administrator and she	e was instructed to give					
		ol at 11:48 a.m. Staff D					
		tor did not assess Resident					
		e administration of the					
		n. The next day (11/30/22) an					
	aide reported someth	-					
		went to the room. Resident					
		awake but not responsive,					
		ould not move. Resident #1					
	⊢would not take her m	edications. Staff D reported	1				1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 SOUTH STONE STREET SIGOURNEY, IA 52591		212312022	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	was standing near conversation, ther And that she was to check on Residual In an interview on Administrator state called in, so she to licensed nurse fro Administrator administrator administrator state headache, was conday. Resident #11 medication and the her pain medication and th	o Staff E. The Administrator rby, listening to the a stated the urinalysis was sent. Ifine. Staff F stated Staff E went ent #1. 12/6/22 at 5:00 p.m. the end on 11/29/22 the day nurse pook on the responsibilities of the end 6:00 a.m. to 6:00 p.m. The shifted she does not work the familiar with the residents. The end Resident #1 had a shifted and not acting right that was given as needed pain the Administrator personally gave on at 6:02 p.m. The end at one time that day (unable to of day) she noticed Resident the grant that was at laministrator stated at 2:00 p.m. at 6:00 p.m. Staff F arrived and sing duties. The Administrator ne had approached her that day but Resident #1? The end yes, they all thought she had ther Resident #1 wanted to go to the ministrator stated no, if they had ther. The Administrator stated in assessment on Resident hysician, or notified family of	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		165381	B. WING			C 12/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 900 SOUTH STONE STREET SIGOURNEY, IA 52591	CODE	12/29/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD B THE APPROPRIA	
F 580	treatment can lesser stroke can cause. By knowing the sign you can take quick a life. Signs and symptom *Sudden numbness arm, or leg, especial *Sudden confusion, understanding spece *Sudden trouble see *Sudden trouble wa balance, or lack of co *Sudden severe hea Call 9-1-1 right awa any of these sympto According to the faci Vocational Nurse Policensed nurses are *Observes residents conditions and react physician of resident drugs, treatments and In an interview on 12	ry minute counts, fast in the brain damage that is and symptoms of a stroke, ction and perhaps save a is of stroke include: or weakness in the face, by on one side of the body. It rouble speaking, or difficulty och. It is is in one or both eyes. It is in one or bo	F	580	<u>>Y)</u>	
	have a change in co assessed, have vital notified. The assessi in the progress notes Resident #1's chang been reported during In an interview on 12 Licensed Practical N according to other ca	urse, stated if the residents ndition, they should be schecked, and a physician ment should be documented s. Staff F stated she thought e in condition had already the day shift on 11/29/22. 2/8/22 at 4:42 p.m. Staff E, urse, was informed that aregivers on 11/29/22, I an excruciating headache,				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165381	B. WING				29/ 2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 121	29/2022
WINDSOR	PLACE SENIOR LIVING	CAMPUS			00 SOUTH STONE STREET		
				S	IGOURNEY, IA 52591		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	÷ 15	F:	580			
F 380	unrelieved with medic She was continually or requesting to go to the Resident #1 pulling of headache was not un of her headache after unusual. Staff E state Resident #1 and discordieve her headache would notify the physical In an interview on 12/Nurse Practitioner, state facility in response condition. ARNP1 state she had ever seen Refamiliar with the reside condition. ARNP1 state Staff E that Resident and her urine was four Resident #1 gets concurrinary tract infection. Resident #1 sitting at unable to respond appart ARNP1 stated she spindicated they did not the hospital. The familiar would not want to go stated she had not be #1 had an excruciating day on 11/29/22 and the requesting to go to the she did not know that #1 was cognitively also independently mobile asked if she had been having an excruciating to go to the she did not consider the she had been having an excruciating to go to the she did not know that #1 was cognitively also independently mobile asked if she had been having an excruciating to go to the she did not consider the she had been having an excruciating the she had been have the she had been having an excruciating the she had been have the she	artion throughout the day. In her call light and It hospital. Staff E stated In her call light or having a In her would have assessed In her would have assessed In her sent out. If symptoms persisted he It can and have her sent out. If symptoms persisted he It can and have her sent out. If symptoms persisted he It can and have her sent out. If symptoms persisted he It can and have her sent out. If symptoms persisted he It can and she was not enter the saident #1 and she was not ents past abilities and the sent sent she was informed by If had become incontinent all smelling. Staff E stated It smelling. Staff E stated		580			
	requesting to go to the	g headache, crying and e hospital, would she send stated if the resident was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165381	B. WING				C 29/2022
	ROVIDER OR SUPPLIER			900	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH STONE STREET GURNEY, IA 52591	1 12/	25/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	her to the hospital. A were having an excribefore she had an ac (stroke), would there sending the resident adverse changes. Af medications which castroke down. In an interview on 12 Director of Nursing (I complaints or change thoroughly assessed the progress notes. I significant change, n physician and treat at to be notified and the progress notes. In an interview on 12 Licensed Practical N agency. Staff I stated complaint or change assessed, including pain, and administerimedications when as should be recorded i change in condition i emergency type situate to the resident's need notify emergency mean appropriate. Following the assessment and progress notes or on Staff I stated she wo the communication in	RNP1 asked if a resident uciating headache 24 hours diverse condition change have been any benefit to to the hospital prior to those RNP1 stated yes, there are an slow the progression of a with the progression of a with the progression of a with the properties of the progression of a with the product of the progression of a with the progression of a with the product of the progression of a with the product of the progression of a with the product of the progression of a with the progression of a with the progression of a with the progression of the progressi	F	580			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165381	B. WING _			C 2/29/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 900 SOUTH STONE STREET SIGOURNEY, IA 52591	•	212512022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622 SS=D	he was first contacted by Staff E. He was in mother was not feelir might be a bladder in they reported the lab thought that she had was recently told by a that she felt his moth properly. The son was multiple caregivers we mother was having a day and at some poir sent to the hospital. To changes, and mental signs of a stroke. Bas Inspections and Appet that day failed to take not consulting a physical son was grateful for the hospital for the ho	of Attorney (POA), indicated d by the facility on 11/30/22 formed at that time that his no well and they thought it ifection. Later that same day was negative and they a stroke. The son stated he an aide who had since quit er was not cared for is informed that according to rorking on 11/29/22, his in excruciating headache that not started requesting to be the headache, motor skill status changes were all sed on the Department of eals investigation, the nurse is appropriate action including scician or notifying family. The she information and stated by have agreed to have his pospital. The Requirements (i)(ii)(2)(i)-(iii) and discharge-requirements-remit each resident to and not transfer or and from the facility unless-scharge is necessary for the difference is appropriate. The shealth has improved ident no longer needs the	F 5	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG	, , ,	(X3) DATE SURVEY COMPLETED	
		165381	B. WING _			C 2/29/2022
	ROVIDER OR SUPPLIER	NG CAMPUS		STREET ADDRESS, CITY, STATE, ZIP (900 SOUTH STONE STREET SIGOURNEY, IA 52591	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	status of the resided (D) The health of in otherwise be enda (E) The resident has appropriate notice, under Medicare or Nonpayment applies ubmit the necessary payment or after the Medicare or Medicare in the Medicare or Medicare or Medicare in the Medicare or Medicaresident who beconstant only allow or (F) The facility cea (ii) The facility may resident while the as \$431.230 of this continuous exercises his or hedischarge or transfor safety of the restacility. The facility that failure to transform the facility that failure to transform the facility or discharge is door medical record and communicated to the institution or provided in the said of	the clinical or behavioral ent; adividuals in the facility would ingered; as failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. The sift the resident does not any paperwork for third party including aid, denies the claim and the pay for his or her stay. For a mes eligible for Medicaid after lity, the facility may charge a able charges under Medicaid; sees to operate. In not transfer or discharge the appeal is pending, pursuant to hapter, when a resident or right to appeal a transfer or om the facility pursuant to § is chapter, unless the failure to be rewould endanger the health ident or other individuals in the round document the danger fer or discharge would pose. Jumentation. Jumentation. Jumentation. Jumentation (F) of this must ensure that the transfer rumented in the resident's dappropriate information is the receiving health care	F	522		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
		165381	B. WING			C 12/29/2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVIN			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591	I	12/29/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	(i) of this section. (B) In the case of pa section, the specific be met, facility attern needs, and the servi facility to meet the n (ii) The documentati (2)(i) of this section (A) The resident's pl discharge is necess: (A) or (B) of this section (B) A physician when necessary under particles section. (iii) Information provemust include a minimal responsible for the contact information (C) Advance Directive (B) Resident represeduntact information (C) Advance Directive (D) All special instruongoing care, as approximated (E) Comprehensive (F) All other necessicopy of the resident' consistent with §483 any other document a safe and effective This REQUIREMEN by: Based on clinical represedent interviews to resident to remain in resident agreed to homultiple vacant room	e transfer per paragraph (c)(1) ragraph (c)(1)(i)(A) of this resident need(s) that cannot hots to meet the resident ce available at the receiving eed(s). on required by paragraph (c) must be made by- hysician when transfer or ary under paragraph (c) (1) tion; and in transfer or discharge is ragraph (c)(1)(i)(C) or (D) of ided to the receiving provider num of the following: ion of the practitioner hare of the resident. entative information including we information ctions or precautions for propriate. care plan goals; ary information, including a s discharge summary, i.21(c)(2) as applicable, and ation, as applicable, to ensure	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		165381	B. WING			C 12/29/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	•	12/29/2022
				900 SOUTH STONE STREET		
WINDSOR	PLACE SENIOR LIVIN	G CAMPUS		SIGOURNEY, IA 52591		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 622	F 622 Continued From page 20		F 6	522		
	he left voluntarily an (AMA) for one of four	ving under the premise until d against medical advice r residents reviewed. acility reported a census of				
	Findings include:					
	assessment tool with of 10/26/22, Resider Mental Status (BIMS moderately impaired required limited assi mobility, dressing, to hygiene needs. Res	nimum Data Set (MDS) n assessment reference date nt #4 had a Brief Interview for s) score of 12, indicating I cognition. Resident #4 stance with transfers, pilet use, and personal ident #4's diagnoses included and diabetes mellitus.				
	Discharge, Including (AMA) policy Guidel the community will p the community, and resident from the co a. The transfer is ne welfare and the resident facility; b. The transfer or discharge the facility; b. The transfer or discharge the resident sufficiently so the reservices provided by c. The safety of individuals.	cessary for the resident's dent's needs cannot be met in scharge is appropriate t's health has improved sident no longer needs the vithe facility; viduals in the facility is he clinical or behavioral				
	d. The health of indir otherwise be endang e. The resident has appropriate notice, t	viduals in the facility would				

AND DUAN OF CORRECTION IN IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		165381	B. WING _		,	C 12/29/2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	G CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COL 900 SOUTH STONE STREET SIGOURNEY, IA 52591	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 622	appropriate their rep against medical advi Except in conditions may issue a resident thirty (30)-day advant transfer or discharge The resident may no discharged while an unless failure to discendanger the health other individuals in the will be documented in the resident and/or provided the following notice, in writing and understand, prior to an order the reasons for the reasons for the reasons for the reasons for the Term Ombudsman, reason for the transpeal form and asset form and submitting and understand, prior to an order the reasons for the move and manner they understand, prior to a statement of the including the name, and the including the name, and the state long term of the name, address the state long term of the name, address and telephone number mentally ill or develous applies; and	ent medical needs; s to operate. ddress with residents and if resentative, that leaving ce is not in their best interest. listed above, the community s, and/or his representative a need notice of an impending from our facility. It be transferred or appeal of such is in place or harge or transfer would or safety of the resident or ne community. This danger in the medical record. representative will be g information within the language and manner they transfer: transfer or discharge, and e in writing and in language derstand; notice to the State Long note in record; of transfer or discharge; sefer; resident's appeals rights, address and telephone which receives such ation on how to obtain the istance in completing the the appeal hearing request. s, and telephone number of	F 6			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		165381	B. WING			C 2/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 SOUTH STONE STREET SIGOURNEY, IA 52591	•	212312022
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 622	department agend handle appeals or notices. In an interview on #4 stated that whe facility, he was tol Resident #4 state Later, when he waw wanted him to mo Resident #4 state empty rooms in the with the ex-Admin XAdmin was fired place and insisted stated they wanted hallways. Resident finally brought in to either accept a #4 stated he agre roommate and the Resident #4 stated his room, gathere him out the front on thave a place thand was not provi #4 stated he called his ex-wife's home steps and was taken hospital. When he stated they can't jokept him for two darrangements for Resident #4 state small room that we to get to his bather.	mber of the state health by that has been designated to transfers and discharge 12/14/22 at 2:25 p.m. Resident en he initially admitted to the discould have his own room. It he was skilled at that time. It has no longer skilled, the facility we in with a roommate. If he refused, noting there were lee facility. He continued to argue listrator (XAdmin). After the land to move. Resident #4 do empty the rooms in other in the had to move. Resident we have his friend as a len his friend backed out. If the facility staff entered do have his friend as a len his friend backed out. If the facility staff entered do have his friend as a len his friend backed out. If the facility staff entered do now as insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded any medications. Resident do go, was insulin dependent, ded go, was insulin dependent,	F	522		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	, ,	OMPLETED
		165381	B. WING			C 12/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591	I	12/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	stated they had just weeks ago. In an interview on 12 Ex-Director of Nursii the DON from April 12022. The XDON state new Administrate moving residents in room for private pay there was no waiting and no immediate n XDON stated Reside roommate and argumentioned. On 8/3/2 with Resident #4 ab Resident #4 refused informed. According Administrator went the scalated. The Administrator went the paperwork. The her and the social with form. The XDON upset. The XDON swith removing Resident #4 left and corporate office. A zithe issue was discustorporate staff, and In an interview on 12 Ex-Social Worker (Xiseveral changes in 12 in 2022.	e resides today. Resident #4 brought in a roommate two 2/20/22 at 3:20 p.m. the ng (XDON) stated she was through November 14th, ated shortly after the arrival of or, they were directed to start with roommates to make residents. The XDON stated g list for private pay residents eed for vacant rooms. The ent #4 did not want a ed whenever it was 22 the XDON again discussed out getting a roommate. I and the Administrator was to the XDON the o Resident #4's room and it inistrator returned to the and stated Resident #4 was ical advice (AMA) and to get XDON stated that between orker (XSW) they filled out I stated Resident #4 was very rated she was not involved lent #4's belongings. The as uncomfortable with how voiced her concerns to their oom meeting took place and seed with the Administrator, the XDON. 2/20/22 at 4:19 p.m. the (SW) stated the facility had management in the past year. dministrator started, she	F6	522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		С	
		165381	B. WING			12/	29/2022
	ROVIDER OR SUPPLIER	G CAMPUS	•	9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH STONE STREET SIGOURNEY, IA 52591	•	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	roommates. The XSV understand why the A for roommates since been in rooms for a loseveral vacant rooms instructed the XSW to notices, which includ stated she was able alternative placement placement for Reside roommate issue cannot understand why Administrator and the room. Resident #4 whave a roommate anyelling at him, stating or leaving AMA, what Administrator would a speak and keep sayir roommate or AMA. R finally said I'm leaving fine, have him sign the maintenance guy them outside the from escorted out. The XS was present and escorted to a Social and written by the XS let Resident #4 known his items to his side of the closest and Resident got loud in the lobby then said by law it is to live that he likes. T	esidents were to have N stated she did not Administrator was pushing several of the residents had ong time and they had s. The Administrator o start giving 30 day eviction ed Resident #4. The XSW to assist some residents with t, but could not find	F	622			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		165381	B. WING		C 12/29/2022		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 SOUTH STONE STREET SIGOURNEY, IA 52591		1212312022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 622	Local Deputy Sherif was called to the far peace regarding a to Two residents, Residents, Resident gasked to shar pending admission was very upset and share a room or lea obvious Resident #felt he had no choice entered his room, peags and escorted leading with his belongings left him. The LDS storiend and went to he wife lives, who is in LDS stated he did in facility could force a no place to go. In an interview on 1 Administrator was a conversation with Red Administrator asked #4 left AMA? The Adwas Resident #4's resusually would have Administrator stated.	ge 25 2/21/22 at 10:53 a.m. the f (LDS) stated on 8/3/22 he cility to intervene and keep the enant dispute with the facility. dent #4 and Resident #5 were e a room to allow room for a from the hospital. Resident #4 given the choice to either ve AMA. LDS stated it was did not want to leave, but he e. The LDS stated the staff laced his belongings into trash Resident #4 in his wheelchair, to the front of the building and ated Resident #4 called a is home in Arson where his the process of divorcing. The ot feel it was right that a resident #4 on 8/3/22. The lif that was the day Resident dministrator then stated she niece by marriage, so she someone else talk to him. The I she did not recall the and with him that day. The	F 62	22			
	it was necessary for The Administrator so that was a long time In a statement on 1: phone call, the facili	sked if she remembered why Resident #4 to share a room. tated she did not recall, noting ago. 2/20/22 at 5:12 p.m. during a ties Corporate Manager nable to locate an AMA form					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			7 50.25			С	
		165381	B. WING _			12/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
WINDSOR	PLACE SENIOR LIVING	CAMPUS		900 SOUTH STONE STREET SIGOURNEY, IA 52591			
	OUR MARK OT	ATEMENT OF DEFINITION		, 		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CORRECTION DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622	Continued From page	e 26	F 6	522			
	related to Resident #4	1's discharge on 8/3/22.					
F 623 SS=D	12:00 p.m. and writte and his belongings we had someone to pick Notice Requirements	Before Transfer/Discharge	F€	623			
	§483.15(c)(3) Notice Before a facility transfersident, the facility m (i) Notify the resident representative(s) of the reasons for the m language and manne facility must send a corepresentative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required ur made by the facility a resident is transferred (ii) Notice must be made before transfer or disc (A) The safety of individe endangered under this section;	before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. It is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. If in paragraphs (c)(4)(ii) and the notice of transfer or order this section must be to least 30 days before the did or discharged. and as soon as practicable					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		165381	B. WING _			C 12/29/2022	
	ROVIDER OR SUPPLIER	G CAMPUS		STREET ADDRESS, CITY, STATE 900 SOUTH STONE STREET SIGOURNEY, IA 52591	E, ZIP CODE	12/25/2022	
(X4) ID PREFIX TAG			ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 623	be endangered, under this section; (C) The resident's he allow a more immediunder paragraph (c)((D) An immediate trarequired by the residunder paragraph (c)((E) A resident has not days. §483.15(c)(5) Content notice specified in paragraph (c)(i) The reason for trace (ii) The effective date (iii) The location to we transferred or dischala (iv) A statement of the including the name, and telephone number eceives such request to obtain an appeal from the protection and addressed in the protection and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities and Bill of Rights Actorising the form the protection and the protection an	er paragraph (c)(1)(i)(D) of ealth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; unsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or of resided in the facility for 30 on the soft the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; of transfer or discharge; thich the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which ests; and information on how orm and assistance in and submitting the appeal ses (mailing and email) and the Office of the State budsman; ty residents with intellectual disabilities or related and email address and the agency responsible for dvocacy of individuals with illities established under Part and Disabilities Assistance of 2000 (Pub. L. 106-402,	F	523			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		165381	B. WING _				C 29/2022	
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	CAMPUS		90	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH STONE STREET IGOURNEY, IA 52591	1 12/	<i>E3/E3EE</i>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 623	email address and tel agency responsible for advocacy of individual established under the for Mentally III Individual §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification prito the State Survey A State Long-Term Care the facility, and the rewell as the plan for the relocation of the residual the plan for the relocation of the residual the plan for the state Survey A State Long-Term Care the facility, and the rewell as the plan for the relocation of the residual the plan for the plan for the residual the plan for the residual the plan for the plan for the residual the plan for the plan for the residual the plan for the residual the plan for th	sabilities, the mailing and ephone number of the or the protection and als with a mental disorder Protection and Advocacy uals Act. The set to the notice. The notice changes prior to or discharge, the facility sients of the notice as soon the updated information The facility must provide or to the impending closure gency, the Office of the et ombudsman, residents of sident representatives, as et ransfer and adequate	F	523	DEFICIENCY)			
	24. Findings include: According to the Mini assessment tool with	Assessment Reference						
	Date of 10/26/22, Res Interview for Mental S	Status (BIMS) score of 12,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		165381	B. WING			C 12/29/2022	
	ROVIDER OR SUPPLIER PLACE SENIOR LIVIN			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591	I	12/29/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	Continued From pa	ge 29	F 62	23			
	Resident #4 require transfers, mobility, of personal hygiene ne	ly impaired cognition. d limited assistance with dressing, toilet use, and eeds. Resident #4's diagnoses ficiency and diabetes mellitus.					
	Discharge, Including (AMA) policy Guide the community will put the community, and resident from the coa. The transfer is not welfare and the resist the facility; b. The transfer or discounts of the community.	cilities Transfer and/or g Against Medical Advice lines revised October 2022 permit a resident to remain in not transfer or discharge the permunity unless: ecessary for the resident's ident's needs cannot be met in scharge is appropriate nt's health has improved					
	sufficiently so the reservices provided be c. The safety of indicendangered due to status of the resider d. The health of indicaterwise be endangered.	esident no longer needs the y the facility; viduals in the facility is the clinical or behavioral nt; ividuals in the facility would gered;					
	appropriate notice, f. An immediate tran by the resident's urg g. The facility cease If the need arises, a appropriate their repagainst medical advicement in conditions may issue a resider thirty (30)-day adva transfer or discharg The resident may not the conditions of the conditio	es to operate. Inddress with residents and if oresentative, that leaving vice is not in their best interest. Is listed above, the community ont, and/or his representative a need notice of an impending of from our facility.					
	discharged while ar	or be transieried of appeal of such is in place or charge or transfer would					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED		
		165381	B. WING _		1	C 2/ 29/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591	1 1/		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	other individuals in the will be documented in The resident and/or provided the following notice, in writing and understand, prior to - The reason for the reasons for the move and manner they understand the following the name, and the including the name, number of the entity requests; and inform appeal form and assistent and submitting - The name, address and telephone number and tele	or safety of the resident or the community. This danger in the medical record. The presentative will be go information within the language and manner they stransfer: transfer or discharge, and the in writing and in language derstand; the interest of the State Long mote in record; the fransfer or discharge; the safer; the safer; the safer of the state language derstand; the interest of the state language derstand; the safer of transfer or discharge; the safer; the safer of the state language derstand; the safer of the safer of the state language derstand; the safer of the state health that has been designated to the safers and discharge the safers and discharge the safer of the state health that has been designated to the safers and discharge the safer of the state health the initially admitted to the safers and discharge the safer of the state health the initially admitted to the safer of the state health that has been designated to the safers and discharge the initially admitted to the safers and skilled at that time. The language the safers will be safer of the facility the safellation on longer skilled, the facility the safellation on the safety of the safellation on the safety of the safellation of the safety of the safellation of the safellat	F6	323			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATIO	NI NII IMDED:	•	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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16	55381 B.	WING			9/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR PLACE SENIOR LIVING CAMPUS			900 SOUTH STONE STREET		
			SIGOURNEY, IA 52591		
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
empty rooms in the facility. He continumith the ex-Administrator (XAdmin). A XAdmin was fired a new Administrator place and insisted he had to move. Restated they wanted to empty the room hallways. Resident #4 stated (on 8/3/2 finally brought in the Deputy Sheriff are to either accept a roommate or leave. #4 stated he agreed to have his friend roommate and then his friend backed Resident #4 stated that the facility state his room, gathered his belongings, and him out the front door. Resident #4 stated he aplace to go, was insulin deand was not provided any medications #4 stated he called his nephew and ghis ex-wife's home. That evening he for steps and was taken by ambulance to hospital. When he told his story, the his stated they can't just kick you out. The kept him for two days, before making arrangements for him to return to the Resident #4 stated he was initially return small room that was so cluttered he was to get to his bathroom. Resident #4 stated he was to room 32, where he resides today. For stated they had just brought in a room weeks ago. In an interview on 12/20/22 at 3:20 p.1 Ex-Director of Nursing (XDON) stated the DON from April through Novembe 2022. The XDON stated shortly after the new Administrator, they were direct moving residents in with roommates to room for private pay residents. The XI	after the or took her esident #4 his in other 22) they had was told. Resident did as a lout. Aff entered hid escorted had escorted had escorted hid espendent, as. Resident hot a ride to fell down her to the hospital he hospital he hospital he hospital he had that as later moved Resident #4 himate two him. The dishe was er 14th, the arrival of hotel to make	F 62	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		165381	B. WING _			C 12/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	1212912022	
				900 SOUTH STONE STREET			
WINDSOR	PLACE SENIOR LIVIN	IG CAMPUS		SIGOURNEY, IA 52591			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 623	Continued From pa	ge 32	F 6	23			
	XDON stated Resid roommate and argu mentioned. On 8/3/2 with Resident #4 refused informed. According Administrator went the escalated. The Administrator went the paperwork. The her and the social with form. The XDON swith removing Resid XDON stated she with Resident #4 left and corporate office. A zero with room with the form.	22 the XDON again discussed out getting a roommate. d and the Administrator was to the XDON the to Resident #4's room and it inistrator returned to the and stated Resident #4 was lical advice (AMA) and to get XDON stated that between worker (XSW) they filled out a stated Resident #4 was very tated she was not involved then #4's belongings. The was uncomfortable with how I voiced her concerns to their coom meeting took place and ssed with the Administrator,					
	Ex-Social Worker (X) several changes in I When the current Ad almost immediately Medicaid/Medicare roommates. The XS understand why the for roommates since been in rooms for a several vacant room instructed the XSW notices, which inclustated she was able alternative placeme placement for Residence.	2/20/22 at 4:19 p.m. the (SW) stated the facility had management in the past year. dministrator started, she began insisting residents were to have SW stated she did not Administrator was pushing a several of the residents had long time and they had his. The Administrator to start giving 30 day eviction ded Resident #4. The XSW to assist some residents with hit, but could not find lent #4. On 8/3/22 the me up again. Resident #4 did					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165381		` '	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		165381 B. \				C 12/29/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 900 SOUTH STONE STREET SIGOURNEY, IA 52591		212312022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 623	Administrator and the room. Resident #4 whave a roommate ary yelling at him, stating or leaving AMA, what Administrator would speak and keep say roommate or AMA. If finally said I'm leaving fine, have him sign to the maintenance guithem outside the from escorted out. The XX was present and escorted out. The XX was present and escorted front door. According to a Social and written by the XX let Resident #4 known his items to his side the closest and Resignost loud in the lobby then said by law it is to live that he likes. To walk out it was not placement. In an interview on 12 Local Deputy Sheriff was called to the face peace regarding a temperature of the peace regarding at the Two residents, Resident gasked to share pending admission for was very upset and share a room or leave obvious Resident #44 to the face of the peace regarding at the two residents, Resident gasked to share a room or leave obvious Resident #44 to the face of the peace regarding at the two residents, Resident #44 to the face of the peace regarding at the face of the peace regarding at the face of the face of the peace regarding at the face of the peace regarding at the face of t	he needed a roommate. The e XSW went to Resident #4's was asking why he had to ad the Administrator began g you are getting a roommate at is it going to be. The not allow Resident #4 to ing what is it going to be, Resident #4 got so upset he ag. The Administrator said the papers. The XSW stated by gathered his belongings, sat ant door and Resident #4 was SSW stated the Deputy Sheriff corted Resident #4 to the all Services Note dated 8/3/22 SW, Housekeeping went to wishe was going to rearrange of the room and one side of dent #4 was not very happy, and threatened to leave and our right to find him a place The XSW told him if he was at our responsibility to find him a place The XSW told him if he was at our responsibility to find him a place aroom to allow room for a room the hospital. Resident #4 given the choice to either we AMA. LDS stated it was a did not want to leave, but he as The LDS stated the staff	F 6	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		165381	B. WING _			C 12/29/2022
NAME OF PROVIDER OR SU WINDSOR PLACE SENI		G CAMPUS		STREET ADDRESS, CITY, STATE, ZIP 900 SOUTH STONE STREET SIGOURNEY, IA 52591	CODE	12/23/2022
PREFIX (EACH	DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIA	
bags and es with his beld left him. The friend and wife lives, with LDS stated facility could no place to a line an intervity Administrate conversation Administrate conversation Administrate conversation Administrate it was necessarily and his beld had someon ADL Care Fig. 1875.	room, plass corted Forgings to progress to his in the did not a go. ew on 12 or was as an with Reformed Forger taked on the harder was as a sary for stated on the facilities was unesident # 20 a progress on the facilities was unesident # 20 a progress on the facilities was unesident # 20 a progress on the facilities was unesident # 20 a progress on the facilities was unesident # 20 a progress on the facilities was unesident # 20 a progress on the facilities of the facilities was unesident # 20 a progress of the facilities of th	aced his belongings into trash desident #4 in his wheelchair, to the front of the building and ated Resident #4 called a is home in Arson where his he process of divorcing. The offeel it was right that a resident onto the streets with a resident onto the streets with a resident was right that a resident was recalled her esident #4 on 8/3/22. The if that was the day Resident ministrator then stated she have been been else talk to him. The she did not recall the did with him that day. The sked if she remembered why Resident #4 to share a room. Ated she did not recall, noting ago. If 20/22 at 5:12 p.m. during a lies Corporate Manager hable to locate an AMA form the she was a finally to locate an AMA form the she was a she were discharge on 8/3/22 at the by the XDON, Resident #4 were discharged AMA and he is him up.	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		165381	B. WING			C 12/29/2022
	ROVIDER OR SUPPLIER	ı	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591			12/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	personal and oral hy. This REQUIREMENT by: Based on clinical reconstant staff interviews, the foresidents were provided accordance with professidents who could independently. (Resireported a census of Findings include: In an interview on 12 Certified Nurse Aide, aide Monday through worked, unless there scheduled. Then she and showers would record to the staff document show records (EMR). Whe or are left blank, it into get a shower that day According to the Min assessment tool with Date of 10/26/22, Resident #4 required transfers, mobility, dipersonal hygiene new	good nutrition, grooming, and giene; T is not met as evidenced cord reviews, resident, and acility failed to ensure ded bathing opportunities in fessional standards to hal hygiene for 3 of 3 not carry out the activity dent #4, #6, #7) The facility 24. 24. 29/22 at 12:30 p.m. Staff M, stated she was the shower of Thursday, when she were only two aides would have to work the floor not get done. Staff M stated f two aides working and titing done. Staff M stated the ers in the electronic medical in entries have a NA in them dicates the resident did not your many compact of the state	F			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		165381	B. WING _			C 12/29/2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVIN	G CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODI 900 SOUTH STONE STREET SIGOURNEY, IA 52591			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 677	should be allowed to wanted. Resident #4 shower in a week ar a week.	ge 36 ne believed the residents o shower as often as they I stated he has not had a nd rarely gets a shower twice IR bathing records, Resident	Fé	577		
	#4 appeared to be s Mondays and Thurs Resident #4 missed last had a shower 1 According to the Mir	cheduled for showers on days. In the last 60 days, 5 shower opportunities and week ago (12/22/22). nimum Data Set (MDS) h Assessment Reference				
	Date of 10/7/22, Res Interview for Mental indicating intact cog extensive assistance dressing, toilet use, Resident #6's diagn	sident #6 had a Brief Status (BIMS) score of 14, nition. Resident #6 required with transfers, mobility, and personal hygiene needs.				
		2/27/22 at 12:30 p.m. ed she did not always get her				
	#6 should receive sho	IR bathing records, Resident nowers on Mondays and R indicated Resident #6 did r on 11/7, 11/24, and 12/19 ays.				
	assessment tool wit Date of 12/2/22, Res Interview for Mental indicating intact cog limited assistance w	nimum Data Set (MDS) h Assessment Reference sident #7 had a Brief Status (BIMS) score of 15 nition. Resident #7 required ith transfers, mobility, and personal hygiene needs.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		165381	B. WING			1	C 29/2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	CAMPUS		90	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH STONE STREET GOURNEY, IA 52591		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684 SS=J	obstructive pulmonar disorder. In an interview on 12/Resident #7 reported getting his showers, received one shower According to the EMF #7 has only had three	ses included bipolar nia, paralytic gait, chronic y disease, and a seizure /27/22 at 12:00 p.m. being frustrated with not noting he was lucky if he		684			
	§ 483.25 Quality of car Quality of care is a furth applies to all treatment facility residents. Bass assessment of a resident residents receives accordance with profest practice, the compreserved reare plan, and the resident REQUIREMENT by: Based on clinical receinterviews, the facility comprehensive assess persistent and excruded line, and a change four residents reviews lack of a comprehensing Resident #1, this results Jeopardy incident. On PM, the lowa Departs	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure is treatment and care in essional standards of inensive person-centered sidents' choices. To is not met as evidenced ford reviews and staff of failed to complete a issment on a resident with a citating headache, motor skill is in mental status for one of ed (Resident #1). Due to the sive assessment for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	1, ,	ATE SURVEY DMPLETED	
		165381	B. WING _			C 12/29/2022	
	ROVIDER OR SUPPLIER PLACE SENIOR LIVIN	IG CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591			12/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From pag Jeopardy. The facili	ge 38 ty reported a census of 24.	F 6	684			
	Findings include:						
	assessment tool wit Date of 10/20/22, R Interview for Mental indicating moderate Resident #1 require transfers, mobility, of personal hygiene no diagnoseis included	nimum Data Set (MDS) h an Assessment Reference esident #1 had a Brief Status (BIMS) score of 10, ly impaired cognition. d limited assistance with dressing, toilet use, and eeds. Resident #1's coronary artery disease, lure, hypertension, and					
	Certified Nurse Aide Tuesday, 11/29/22 s 2:00 p.m. shift. That already up in her rec Resident #1 usually 10:00 a.m. Residen headache and cons At 6:15 a.m. Staff A complaints of a sevenurse who happene The Administrator si been given pain me Administrator if the told no, so Staff A ge placed them on Res Staff A stated the we Resident #1 was ba minute wanting in he back in her recliner. her and told her the	2/5/22 at 3:14 p.m. Staff A, e (CNA), stated that on she worked a 6:00 a.m. to a morning, Resident #1 was cliner, this was unusual as slept in until 9:00 a.m. to a t#1 was complaining of a stantly pulling on her call light. The reported Resident #1's ere headache to the charge of the the date of the the date of the the date of the the facility had ice packs and was not some wet washcloths and sident #1's neck and head. The t					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		OMPLETED	
		165381	B. WING			C	
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	1		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591		12/29/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	conversation, was in and could walk indep Resident #1 was also continued to complate Staff A stated she condinistrator that Reflexer excruciating headach to the hospital. Staff seemed more interest organizing the medic the resident. By 12:00 Resident #1 became yelling she needed to outbursts were so distincted in Resident #1 commenting to the A was crying and want A stated Resident #1 stated I was a nurse A stated Staff B and Resident #1's cries f was done. Staff A stated Staff B and Resident #1's cries f was done. Staff A stated Staff B and Resident #1. Reside from her shoulders to E witnessed the resignistructed Staff A to get the stated once she beg she knew immediate Resident #1 was una side. There was noth a vegetable. Staff E and she assisted him	ely alert, could carry on a dependent with most care, bendently using her walker. The control of a nurse. Resident #1 in of a severe headache and intinued to report to the desident #1 was having an and requesting to be sent A indicated the Administrator sted in cleaning and reation room than attending to	F	584			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165381	B. WING _			1	C 29/2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	CAMPUS		900 S	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH STONE STREET DURNEY, IA 52591	1 12/	ZJIZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684		ff E responded maybe. Staff	F	684			
	A stated she changed times that day and Ro any signs of improved Monday, 11/28/22, Ro independent and in the	d Resident #1's bed three esident #1 never showed ment. Staff A stated on					
	clarification. Staff A state to the on-coming aide 11/29/22. Staff A state Resident #1 had been complained of a seve day. Staff A stated Rego to the hospital. Staff	re headache throughout the esident #1 was requesting to aff A explained that the for condition and Resident					
	CNA, stated that she p.m. on Monday, 11/2 remembered Resider with staff, independer and being her normal needed assistance w Tuesday, 11/29/22, Suntil 2:00 p.m. That m Resident #1 was complete the morning progress worsened into a migrorequesting to be sent Administrator stated to something and stated complains, but she is never saw the Admini#1. Resident #1 contil	25/22 at 4:55 p.m. Staff B, worked 6:00 a.m. to 2:00 28/22. Staff B stated she at #1 being alert, conversing atly mobile using her walker, self. Resident #1 only ith incontinence cares. On taff B worked from 6:00 a.m. arrived, aplaining of a headache. As sed, Resident #1's headache aine. Resident #1's headache aine. Resident #1 began to the hospital. The they had already given her I that is just Resident #1 she fine. Staff B stated she istrator check on Resident nued to complain of an are and continually pulled on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED		
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NAME OF PE	ROVIDER OR SUPPLIER	100001	1	STREET ADDRESS, CITY, STATE, ZIP COL		2/29/2022	
TO AVIL OF TH	TO VIDER OR GOT FEILING			900 SOUTH STONE STREET	<i>5</i> 2		
WINDSOR	PLACE SENIOR LIVIN	IG CAMPUS		SIGOURNEY, IA 52591			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From page	ge 41	F 6	84			
		nout her shift. Resident #1 urse, I know they can help					
	for clarification. Star with the Administrat informed her that Re go to the hospital. A said she already ga	a.m. Staff B was interviewed if B stated when she spoke or about Resident #1, she esident #1 was requesting to at that time the Administrator we her something for pain. dded that she complains, but					
	Marketing, stated sl a.m. on 11/29/22. S approached her with #1. The aides stated complaining of an erequesting to go to indicated they had it several times, but stated she went to the expressed her condicated she went to the pain medication) and for a urinalysis. Stated Administrator never that day. Staff C stated #1 was grabbing at Resident #1 wanted stated Resident #1 most of the day condicated by late that afternoof garbled. She was not wednesday, 11/30/	n concerns related to Resident d Resident #1 was excruciating headache and the hospital. The aides informed the Administrator he was doing nothing. Staff C he Administrator and ern. The Administrator stated dent #1 a Tramadol (controlled d they were getting an order ff C stated that the saw or assessed Resident #1 ited that afternoon Resident her head and screaming. It to go to the hospital. Staff C had been cognitively alert inplaining of a headache, but on her speech had become ot alert and confused. On 22, Resident #1's right side					
	garbled. She was no Wednesday, 11/30/2 was flaccid, she wa no right-side vision.	ot alert and confused. On					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER:		G	COMPLETED	(X3) DATE SURVEY COMPLETED	
165381	B. WING		C	22	
100001		STREET ADDRESS, CITY, STATE, ZIP CODE	•	022	
		900 SOUTH STONE STREET			
		SIGOURNEY, IA 52591			
RECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE COM	(X5) MPLETION DATE	
	F 6	84			
ite medical					
ncluded Resident bital when esident 1's red late that beech became eed. 05 a.m. Staff D, d she worked 6:00 and was assigned uled nurse called for the absent estrator remained and organizing the started setting #1's call light sident #1 was ff D assisted ant #1 was having ausual for her. wilet and returned ight came on alped Resident blanket. Moments for help. Staff D and then again #1 continued to r aides voiced staff D asked the eent #1. Staff D hecked on spite being					
	DEFICIENCIES RECEDED BY FULL ING INFORMATION) ate medical was contacted for ncluded Resident pital when esident 1's orted late that peech became sed. 305 a.m. Staff D, d she worked 6:00 and was assigned uled nurse called for the absent strator remained and organizing he started setting #1's call light esident #1 was ff D assisted ent #1 was having husual for her. Dilet and returned light came on helped Resident blanket. Moments for help. Staff D asked the lent #1. Staff D asked the lent #1. Staff D hecked on spite being hes. Staff D asked the lent #1.	DEFICIENCIES RECEDED BY FULL ING INFORMATION) TAG THE MEDICAL MARKET TO THE PREFIX TAG TAG THE MEDICAL MARKET TO THE PREFIX TAG THE MEDICAL MARKET TO THE PREFIX TAG THE MEDICAL MARKET TAG THE MARKET TAG THE MEDICAL	THE STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591 DEFICIENCIES RECEDED BY FULL ING INFORMATION) TAG PREFIX TAG PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) F 684 THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY) THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL DEFICIENCY THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE ALL THE MANUAL PROVIDER'S PLAN OF COR (EACH CORRE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591 DEFICIENCIES RECEDED BY FULL ING INFORMATION) PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 THE FORMATION OF THE APPROPRIATE DEFICIENCY THE	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591	12	12912022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	from about 10:00 a.m returning, Resident # in pain. Staff D said s Administrator and she Resident #1 Tramado stated the Administra #1 prior to or after the controlled medication aide reported someth Resident #1. Staff D #1 was sitting in bed would not talk, and w would not take her me her observations to S was standing nearby, conversation, then stand that she was fine to check on Resident In an interview on 12/Administrator stated called in, so she took licensed nurse from 6 Administrator admitte floor and was not fam Administrator stated I headache, was confuday. Resident #1 was medication and the Aher pain medication stated at specify the time of #1's oxygen tubing kr checked the oxygen s 91%-92%. The Admin Staff D left, then at 6: took over the nursing	t setting up medications . until 12:00 p.m. Upon 1 was continuing to cry out omething to the e was instructed to give of at 11:48 a.m. Staff D tor did not assess Resident e administration of the . The next day (11/30/22) an ing was wrong with went to the room. Resident awake but not responsive, ould not move. Resident #1 edications. Staff D reported taff E. The Administrator listening to the ated the urinalysis was sent. e. Staff F stated Staff E went #1. 6/22 at 5:00 p.m. the on 11/29/22 the day nurse on the responsibilities of the e:00 a.m. to 6:00 p.m. The d she does not work the uilliar with the residents. The Resident #1 had a sed, and not acting right that is given as needed pain dministrator personally gave	F 6	84		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165381	B. WING				29/ 2022
	ROVIDER OR SUPPLIER PLACE SENIOR LIVING	CAMPUS	•	9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH STONE STREET SIGOURNEY, IA 52591		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	COVID. They told he headache. The Admi anyone told her Residenspital? The Admini I would have sent her she never charted an #1, consulted a physic Resident #1's condition. According to the Cen Prevention (CDC) infrand Symptoms dated During a stroke ever treatment can lessen stroke can cause. By knowing the significant you can take quick as life. Signs and symptoms *Sudden numbness arm, or leg, especiall *Sudden confusion, understanding speece *Sudden trouble wall balance, or lack of cota *Sudden severe hear Call 9-1-1 right away any of these symptoms (CNA, stated she work on 11/29/22. In report Resident #1 was not had a headache. State complaining of a major standing of a ma	Resident #1? The yes, they all thought she had r Resident #1 had a nistrator was asked if dent #1 wanted to go to the strator stated no, if they had r. The Administrator stated assessment on Resident ician, or notified family of on. Iters for Disease Control and ormation on Stroke Signs March 4, 2022: y minute counts, fast the brain damage that as and symptoms of a stroke, ction and perhaps save a sof stroke include: or weakness in the face, y on one side of the body. trouble speaking, or difficulty h. ing in one or both eyes. king, dizziness, loss of ordination. dache with no known cause. If if you or someone else has	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED	
		165381	B. WING _			C 12/29/2022	
	ROVIDER OR SUPPLIER PLACE SENIOR LIVIN	G CAMPUS	,	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591		12/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)		
F 684	Continued From pag		F	684			
	Resident #1 to the b during her shift. Sta normally independe	S stated she assisted athroom a couple times of G stated Resident #1 was nt, so it was unusual for her but that evening she was es.					
	CNA, stated she wo p.m. to 6:00 a.m.) or that Resident #1 sle but had slid out of be morning. Staff H sta Resident #1's condition	2/7/22 at 10:30 p.m. Staff H, rked the overnight shift (10:00 in 11/28/22. Staff H recalled pt through most of the night, ed at around 5:45 a.m. that ted she noted no change in ion. Staff H stated she g (11/29/22) for the overnight					
	shift and was inform a headache that day had a urinary tract ir not unusual for Resi and receive Tylenol. a.m.) Resident #1 w	ed in report Resident #1 had and that they suspected she affection. Staff H stated it was dent #1 to have headaches Shortly after midnight (12:29 as discovered on the floor in Resident #1 was disoriented,					
	saying what, what. If understand or respo was the first time sh change in Resident independent and red now require total cal	Resident #1 was unable to and to staff. Staff H stated this had noticed a dramatic #1's condition who had been quired minimal assistance to re, have to be checked for et changed as needed.					
	stated she was an a several shifts at the Resident #1. Staff F overnight shift (6:00 11/28/22. Staff F red during her shift. Res headache and was g	2/8/22 at 12:50 a.m. Staff F gency nurse, but has worked facility and was familiar with stated she worked the p.m. to 6:00 a.m.) on salled Resident #1 being fine ident #1 complained of a given Tylenol at 5:45 a.m. of her bed when she sat up to					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUC			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591		12/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	On 11/29/22, Staff F work another overnig Administrator stated differently and she wand put in an order. mention of Resident that day or of her chevening, Resident # help. Resident #1 wand completely confattributed the confus based on the inform Administrator. Staff change in condition with a physician. Stachange in condition, have their vitals chenotified. The assess in the progress note Resident #1's change been reported. In an interview on 12 LPN, stated he has a several years and know the stated 6 months ago bout of pulmonary enthat time, she was how returning to the facilia supplement and her was placed on hosp adamant that she did hospital. Eventually about a month ago services. Resident # independently and rewith care. Resident in with care. Resident in the stated in the services. Resident # independently and rewith care. Resident in the stated in the services. Resident # independently and rewith care. Resident in the stated in the services. Resident # independently and rewith care. Resident # independently and rewith care.	Resident #1 was not injured. returned to the facility to ght shift. In report the Resident #1 had been acting vas wanting to get a urinalysis The Administrator made no #1's complaints of headache ange in condition. Early that 1 was screaming help, help, as assisted to the bathroom used. Staff F stated she sion to a urinary tract infection ation she was given from the F stated she thought the had already been discussed aff F stated if a resident had a they should be assessed, cked, and a physician ment should be documented s. Staff F stated she thought te in condition had already 2/8/22 at 4:42 p.m. Staff E, taken care of Resident #1 for nows the family well. Staff E to Resident #1 went through a dema and hypoxia. During ospitalized and upon ty she was placed on oxygen condition was such that she ice services. Resident #1 was d not want to return to the Resident #1 recovered and she was taken off hospice the was able to toilet equired minimal assistance	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		. ,	(X3) DATE SURVEY COMPLETED			
		165381	B. WING			C 2/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 900 SOUTH STONE STREET SIGOURNEY, IA 52591		212312022
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 684	6:00 p.m.) on 11/3 had worked in four informed by Staff I increased disorient restlessness. Followsee Resident #1.0 noticed was a strothis was unusual acontinent. Resider grabbing her blank bed. Resident #1 directions and was answer made sense her pupils which is light, but was unal Resident #1's non also noticed Resident #1's non also noticed Resident worker for a urinally sample to rule out infection (UTI). Methe Advanced Resident #1 on an would assess Resia.m. to 9:30 a.m. Resident #1 on an would see whether so treat according to be consulted what aggressive treatm stated by the end arm was pulled up wrist contractured Resident #1 had he contacted the fam condition and that	d the day shift (6:00 a.m. to 0/22. It was the first time he r days. In report he was F, that Resident #1 fell, had station, agitation, and owing the report, Staff E went to One of the first things he ang odor of urine. Staff E stated as Resident #1 was normally a nt #1 was in her bed restless, sets, and throwing them off her was not responding to a saying words, but not every see. Staff E stated he checked eemed equal and reactive to oble to check hand grips due to compliance. Staff E stated he lent #1 holding her right arm her right wrist slightly f E stated they have a standing sis (UA), so he collected a urine a possible urinary tract eanwhile Staff E stated he knew gistered Nurse Practitioner visiting that morning and she ident #1 further. At around 9:00 ARNP1 visited and started antibiotic. ARNP1 stated they r Resident #1 had a UTI and if ly. Otherwise the family needed mether they wanted more ent or comfort care. Staff E of that day, Resident #1's right or against her body and right. At that time Staff E stated he lily informing them of her she had probably had a stroke. they did not want her	F	684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		165381	B. WING _			C / 29/2022
NAME OF P	ROVIDER OR SUPPLIER	1111		STREET ADDRESS, CITY, STATE, ZIP CODE	12	12312022
				900 SOUTH STONE STREET		
WINDSOR	PLACE SENIOR LIVING	CAMPUS		SIGOURNEY, IA 52591		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	they would consider in that according to other Resident #1 had an end unrelieved with medic She was continually or requesting to go to the did not know that. Staputting on her call light not unusual, but not gafter receiving medical asked what he would circumstances. Staff assessed Resident # could do to relieve her persisted he would not her sent out. In an interview on 12/2 reported that on 11/3 response to Resident #1 and the residents past abits stated she was inform #1 had become incomfoul smelling. Staff E confused when she her ARNP1 stated she set bedside, restless, and	r condition did not change nospice. Staff E explained or caregivers on 11/29/22, excruciating headache, cation throughout the day. On her call light and e hospital, Staff E stated he aff E stated Resident #1 or having a headache was getting relief of her headache ation was unusual. Staff E have done given these E stated he would have 1 and discussed what they or headache. If symptoms of the physician and have 16/22 at 10:05 a.m. ARNP1 of 22 she visited the facility in #1's change in condition. The was not familiar with littles and condition. ARNP1 ned by Staff E that Resident the tinent and her urine was stated Resident #1 gets as a urinary tract infection.	F 6	,		
	want Resident #1 ser indicated the resident hospital. ARNP1 state informed of Resident excruciating headach 11/29/22 and that Res					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE SENIOR LIVING CAMPUS			STREET ADDRESS, CITY, STATE, ZIF 900 SOUTH STONE STREET SIGOURNEY, IA 52591	P CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	was cognitively alert mobile using her was been contacted abore excruciating headact go to the hospital, ware, she would not hospital. ARNP1 stated if the aware, she would not hospital. ARNP1 ask an excruciating head had an adverse continere have been any resident to the hospic changes. ARNP1 stated medications which of stroke down. In an interview on 12 Director of Nursing (home with COVID of she has only been the worked at the facility stated Resident #1 rewith changing and sombulate with a wall wants and needs, ald DON indicated new provided a job describe surveyor the job LPNs, and Registers residents with compare to be thoroughly documented in the persists or is a significant and reals to the surveyor are also to the surveyor are to be thoroughly documented in the persists or is a significant and physician are also to	e day before, Resident #1 , verbal, and independently lker. ARNP1 asked if she had at a resident having an he, crying, and requesting to ould she send the resident? resident was cognitively of hesitate to send her to the ted if a resident were having dache 24 hours before she dition change (stroke), would of benefit to sending the tal prior to those adverse and slow the progression of a 2/7/22 at 11:30 a.m. the DON) stated she was at an 11/29/22. The DON stated are DON for 3 weeks, but has are for 3-4 months. The DON equired limited assistance ome care. Resident #1 could ker and could verbalize her though did not talk a lot. The nurses and CMAs are iption upon hire and provided descriptions for their CMAs, and Nurses. The DON stated aints or changes in condition assessed, treated, and rogress notes. If a complaint ficant change, nurses are to and treat accordingly.	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		165381	B. WING _			C 12/29/2022	
	ROVIDER OR SUPPLIER PLACE SENIOR LIVIN	G CAMPUS		STREET ADDRESS, CITY, STATE, 900 SOUTH STONE STREET SIGOURNEY, IA 52591	ZIP CODE	12201202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 684	Continued From pag	ge 50	F	684			
	Vocational Nurse Policensed nurses are *The total nursing ca assigned unit. *Assumes responsible Federal, State, Loca *Charts progress no manner that reflects well as the resident's *Observes residents conditions and react physician of residen drugs, treatments ar *Takes temperatures other vital signs to dand assess the cond *Responds to emerging the total resident to the total signs to dand assess the cond *Responds to emerging the total resident to the tot	are of residents in their collity for compliance with all and company regulations. It is in an informative, factual the care administered as a response to care. It is, records significant incidents ions, notifies supervisor or it's conditions and reactions to individual significant incidents. It is, pulse, blood pressure and etect deviations from normal					
	LPN, stated that she stated when a reside in condition, they are checking vital signs, administering as new when appropriate. Trecorded in the progrondition is significal situation, she would needs, consult a phymedical services (El the event, she would contact details in the incident report form. notify family and recoprogress notes. State	2/7/22 at 3:25 p.m. Staff I, a works for an agency. Staff I ent has a complaint or change to be assessed, including rating pain, and eded (PRN) medications he assessment should be ress notes. If the change in nt or an emergency type first attend to the resident's visician, and notify emergency MS) if appropriate. Following a record the assessment and a progress notes or on an Staff I stated she would ord the communication in the ff I stated when giving a PRN orded in the electronic					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED	
		165381	B. WING _			C 12/29/2022	
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE SENIOR LIVING CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 900 SOUTH STONE STREET SIGOURNEY, IA 52591)E	ILILIILULL	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	automatically promptevaluate the effective I stated she would us hour and a half to revevaluate effectivenes prompt will remain of addresses it. According to Resider 11/28/22 at 8:16 p.m. Tramadol HL as need F. 11/28/22 at 11:04 p.r. Staff F. 11/29/22 at 7:14 a.m. milligrams of Tylenol by Staff D.	R) system. The EMR system is a follow up needed to eness of the medication. Staff sually wait 45 minutes to an visit the resident and is. Staff I stated the follow up in the EMR until someone Int #1's progress notes: administered 50 milligrams ded for a headache by Staff Intercorded as effective by	F	584			
	of Tramadol HL as no Staff D. 11/29/22 at 5:53 p.m Administrator. 11/29/22 at 6:02 p.m of Tramadol HL as no Administrator. 11/29/23 at 11:31 p.m Staff F. In an interview on 12 primary care physicia no record of anyone regarding Resident #	n. administered 50 milligrams eeded for a headache by recorded as effective by the administered 50 milligrams eeded for pain by the n. recorded as effective by /6/22 at 4:18 p.m. the an's nurse stated there was from the facility calling 1 on 11/29/22. ved the immediate jeopardy, et to a D prior to the exit of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
						С	
		165381	B. WING _			12/29/2022	
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE SENIOR LIVING CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CO 900 SOUTH STONE STREET SIGOURNEY, IA 52591	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 684	and interventions are assess and documen symptoms. Prolonged to the medical doctor hours after intervention. The Charge Nurse within two hours of insymptoms are not impuil document assess progress notes and on hour report and the previewed Monday through the DON/designee and boweekends and will mass indicated. c. The 24-hour report used to address symplement of the facility provide nurses that when resist symptoms, nurse musprovide interventions. residents, the nurse residents, the nurse residents, the nurse residents are ineffective action will interport every Monday Weekend supervisor progress notes for children interventions of the modern of the mo	pices a physical complaint provided, the nurse will to resolution of the disymptoms will be reported (MD) and family within two ons. will report to MD and family terventions if physical proved. The Charge Nurse ment and actions taken in a 24 hour report. The 24 rogress notes will be ough Friday by the yith charge nurse on the take changes in plan of care and progress notes will be otoms that residents report. If the dent complains of the stassess, document and When reassessing the must document. If the fective, the nurse must call thin two hours. Immediate include reviewing 24 hour through Friday. The will review report and ange in status. The current re-educated prior to working	F	684			